Centre de Médecine Intégrative de Montréal
The Montreal Centre for Integrative Medicine

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Patient Intake Form

Today's Date	**Name** **Maiden Name** (if applicable)	**Date of Birth (DD/MMM/YY)**
Address	**Telephone** Mobile: Home: Work:	**Email**
Physician (circle one) Dr. Gavsie Dr. Jacobson Dr. Doré Dr. Breger Dr. Kanevsky	**Medicare Number**	**Medicare Expiration**

Welcome to the MCIM. We have merged with the well established Centre D'Integration Somatosophique (CIS). We have prepared a questionnaire of pertinent details regarding your history that we ask you to fill out.

We are a holistic, patient-centered clinic with an integrative team approach that differs in some ways from conventional medical clinics. We work as part of a multidisciplinary team in order to best serve you, the patient, and restore and maintain your health and wellness. As such, there are uninsured expenses in order to facilitate this type of practice. With your signature below, you are acknowledging that you have been made aware of these policies by our staff and you consent to our holistic and integrative approach to health and the use of the ***holistic health participation fees***. This integrative approach to healthcare during your care with us often includes the use of conventional western medicine according to current standards of practice.

Please note these policies as well:

1. **Missed appointments**: All appointments must be cancelled a minimum of 2 working days prior to your scheduled visit with our physicians and practitioners. Since we reserve the time slot specifically for you, late cancellations will be subject to **an amount equal to 50% of the holistic health participation fees**.

2. **Test results:** We will notify you of **significant abnormal** test results (lab, diagnostic imaging, and other private testing) and arrange for appropriate follow up with your physician. However, due to the large volume of tests results, we will **not** notify you of **normal** or **non significant abnormal** test results (the determination of non significant abnormal results are at the discretion of the physician). We encourage you to book an appointment with your physician following any testing to go over all results in detail.

3. **Phone consults:** Phone consultations (initial or follow up) are performed by some of our physicians and generally not performed by other physicians, except under special circumstances. Please contact our office for further details.

4. **Privacy Policy:** We greatly value your privacy. Our physicians and therapeutic practitioners are all bound by professional codes regarding confidentiality. However, we are an integrative centre and would ideally share pertinent medical and health information with our internal practitioners or an external practitioner to whom we would refer you. As such, you, as the patient, authorize MCIM/CIS and Drs. Gavsie, Jacobson, Doré, Breger, and Kanevsky and any other affiliated physicians or professionals of the MCIM/CIS to release your pertinent medical information to any physician or health care practitioner to whom you may be referred to by MCIM/CIS or the physicians named above.

_____ _____

Your Signature **Today's Date**

Where can we leave a confidential message? (circle any) Home Work Cell Email

Emergency Contact Name _____
Relationship _____
Phone Numbers Home _____ Other _____

Who referred you to the MCIM? _____

Person completing this form (if other than patient) _____
Relationship to Patient _____

Please list your **current and ongoing medical concerns**:

Describe Problem	Mild	Moderate	Severe
Example: Post Nasal Drip		*x*	
1.			
2.			
3.			

Did something trigger your change in health? _____

Please list the names of **physicians and complementary or alternative medical providers** who have treated you in the recent past

Name	Location/Contact	Profession/Specialty	Dates of Treatment From	To

Please list the names of **psychiatrists, psychologists, counsellors, and psychotherapists** who have treated you in the past:

Name	Location/Contact	Profession/Specialty	Dates of Treatment From	To

Medical History

Diseases/Diagnoses/Conditions

☑ Present Condition ☑ Past Condition
Check appropriate box and provide date of onset

GASTROINTESTINAL

- ❑ ❑ Irritable Bowel Syndrome _____
- ❑ ❑ Inflammatory Bowel Disease _____
- ❑ ❑ Crohn's _____
- ❑ ❑ Ulcerative Colitis _____
- ❑ ❑ Gastric or Peptic Ulcer Disease _____
- ❑ ❑ GERD (reflux) _____
- ❑ ❑ Celiac Disease _____
- ❑ ❑ Other _____

CARDIOVASCULAR

- ❑ ❑ Heart Attack _____
- ❑ ❑ Other Heart Disease _____
- ❑ ❑ Stroke _____
- ❑ ❑ Elevated Cholesterol _____
- ❑ ❑ Arrhythmia (irregular heart rate) _____
- ❑ ❑ Hypertension _____
- ❑ ❑ Rheumatic Fever _____
- ❑ ❑ Mitral Valve Prolapse _____
- ❑ ❑ Other _____

ENDOCRINE AND METABOLISM

- ❑ ❑ Type 1 Diabetes _____
- ❑ ❑ Type 2 Diabetes _____
- ❑ ❑ Hypoglycemia _____
- ❑ ❑ Metabolic Syndrome (insulin resistance or pre diabetes) _____
- ❑ ❑ Hypothyroid (underactive) _____
- ❑ ❑ Hyperthyroid (overactive) _____
- ❑ ❑ Other endocrine problem _____
- ❑ ❑ Polycystic Ovaries (PCOS) _____
- ❑ ❑ Infertility _____
- ❑ ❑ Weight Gain _____
- ❑ ❑ Weight Loss _____
- ❑ ❑ Frequent Weight Fluctuations _____
- ❑ ❑ Anorexia _____
- ❑ ❑ Bulimia _____
- ❑ ❑ Binge Eating Disorder _____
- ❑ ❑ Night Eating Syndrome _____
- ❑ ❑ Eating Disorder (non specific) _____
- ❑ ❑ Other _____

GENITAL AND URINARY SYSTEMS

- ❑ ❑ Kidney Stones _____
- ❑ ❑ Gout _____
- ❑ ❑ Interstitial Cystitis _____
- ❑ ❑ Frequent Urinary Tract Infections _____
- ❑ ❑ Frequent Yeast Infections _____
- ❑ ❑ Erectile Dysfunction _____
- ❑ ❑ Sexual Dysfunction _____
- ❑ ❑ Other _____

MUSCULOSKELETAL/PAIN

- ❑ ❑ Osteoarthritis _____
- ❑ ❑ Fibromyalgia _____
- ❑ ❑ Chronic Pain _____
- ❑ ❑ Other _____

INFLAMMATORY/AUTOIMMUNE

- ❑ ❑ Chronic Fatigue Syndrome _____
- ❑ ❑ Autoimmune Disease (other) _____
- ❑ ❑ Rheumatoid Arthritis _____
- ❑ ❑ Lupus (SLE) _____
- ❑ ❑ Immune Deficiency (other) _____
- ❑ ❑ Herpes-Genital _____
- ❑ ❑ Severe Infectious Disease _____
- ❑ ❑ Food Allergies _____
- ❑ ❑ Poor Immune Function (frequent infections) _____
- ❑ ❑ Environmental Allergies _____
- ❑ ❑ Multiple Chemical Sensitivities _____
- ❑ ❑ Latex Allergy _____
- ❑ ❑ Other _____

RESPIRATORY

- ❑ ❑ Asthma _____
- ❑ ❑ Chronic Sinusitis _____
- ❑ ❑ Bronchitis _____
- ❑ ❑ Emphysema _____
- ❑ ❑ Pneumonia _____
- ❑ ❑ Tuberculosis _____
- ❑ ❑ Sleep Apnea _____
- ❑ ❑ Other _____

CANCER

- ❑ ❑ Lung Cancer _____
- ❑ ❑ Breast Cancer _____
- ❑ ❑ Colon Cancer _____
- ❑ ❑ Ovarian Cancer _____
- ❑ ❑ Prostate Cancer _____
- ❑ ❑ Skin Cancer _____
- ❑ ❑ Leukemia/Lymphoma _____
- ❑ ❑ Other _____

SKIN DISEASES

- ❑ ❑ Acne _____
- ❑ ❑ Eczema _____
- ❑ ❑ Psoriasis _____
- ❑ ❑ Melanoma _____
- ❑ ❑ Fungal Skin Infections
- ❑ ❑ Other _____

NEUROLOGIC/MOOD

- ❑ ❑ Depression _____
- ❑ ❑ Anxiety _____
- ❑ ❑ Bipolar Disorder _____
- ❑ ❑ Schizophrenia _____
- ❑ ❑ Headaches _____
- ❑ ❑ Migraines _____
- ❑ ❑ ADD/ADHD _____
- ❑ ❑ Mild Cognitive Impairment _____
- ❑ ❑ Autism _____
- ❑ ❑ Memory Problems _____
- ❑ ❑ Parkinsons _____
- ❑ ❑ Multiple Sclerosis _____
- ❑ ❑ ALS _____
- ❑ ❑ Seizures _____
- ❑ ❑ Other _____

PREVENTIVE OR DIAGNOSTIC TESTS

Check box if yes and provide date

- ❑ Full physical exam _____
- ❑ ECG _____
- ❑ Cardiac Stress Test _____
- ❑ Chest X-ray _____
- ❑ Stool for Occult Blood _____
- ❑ Colonoscopy _____
- ❑ Bone Mineral Density _____
- ❑ Gastroscopy _____
- ❑ CT Scan _____
- ❑ MRI _____
- ❑ Ultrasound _____
- ❑ Upper GI Series _____

SURGERIES

Check box if yes and provide date of surgery

- ❑ Appendectomy _____
- ❑ Hysterectomy +/- Ovaries _____
- ❑ Gallbladder _____
- ❑ Hernia _____
- ❑ Tonsillectomy _____
- ❑ Dental Surgery _____
- ❑ Joint Replacement (Knee/Hip) _____
- ❑ Heart Surgery (bypass/valve) _____
- ❑ Angioplasty or stent _____
- ❑ Pacemaker _____
- ❑ Other _____
- ❑ None

INJURIES

Check box if yes and provide dates

- ❑ Back Injury _____
- ❑ Head Injury _____
- ❑ Neck Injury _____
- ❑ Broken Bones _____
- ❑ Other _____

What is your Blood Type: ❑ A ❑ B ❑ AB ❑ O ❑ Rh+ ❑ Unknown
Have you had a PSA done? ❑ Yes ❑ No ❑ Not applicable
PSA Level: ❑ 0-2 ❑ 2-4 ❑ 4-10 ❑ > 10

VACCINE HISTORY (Please provide dates of most recent vaccinations)

- ❑ MMR _____
- ❑ Polio (IPV) _____
- ❑ Tetanus/Diptheria/Pertussis (DTaP) _____
- ❑ Tetanus/Diptheria (dT) _____
- ❑ Hepatitis A _____
- ❑ Hepatitis B _____
- ❑ Varicella (Chicken Pox) _____
- ❑ HPV (Gardasil) _____
- ❑ Seasonal Influenza _____
- ❑ Pneumococcus _____
- ❑ Typhoid Fever _____
- ❑ Yellow Fever _____

Please list any **hospitalizations.** ❑ None

Reason for hospitalization	Date

Please list any **prescription medications** or **over the counter (OTC) medications** you are on (Please use an additional page if necessary):

Name	Dose or quantity per day (ie 50mg tablet twice daily)	Date started	Date Stopped

Please list any **vitamins, supplements or remedies** you are taking (Please use an additional page if necessary):

Name	Brand Name	Dose or quantity per day	Date started	Date Stopped

Please list any **allergies or intolerances** to **medications, supplements, foods, or environmental factors** you may have:

Name	Type of reaction	Date first noticed

Have you had prolonged or regular use of NSAIDS (Advil, Aleve, etc.), Motrin, Aspirin? ❑ Yes ❑ No
Have you had prolonged or regular use of Tylenol? ❑ Yes ❑ No
Have you had prolonged or regular use of Acid Blocking Drugs (Tagamet, Zantac, Pantoloc, etc.) ❑ Yes ❑ No
Frequent antibiotics > 3 times/year ❑ Yes ❑ No
Long term antibiotics (>3 months) ❑ Yes ❑ No
Use of steroids (prednisone, nasal allergy inhalers) in the past ❑ Yes ❑ No
Use of oral contraceptives ❑ Yes ❑ No

Do you have any pertinent **family history**?
(Include cancer, heart disease, diabetes, hypertension, high cholesterol, depression, genetic disorders, asthma, eczema, psoriasis, autoimmune disease, Inflammatory Bowel Disease, MS, Parkinsons etc)

Relative	Disease/Condition	Age at diagnosis	Current Age (if still alive)	Age at Death (if deceased)
Mother				
Father				
Sibling				
Sibling				
Children				
Children				
Maternal GF				
Maternal GM				
Paternal GF				
Paternal GM				
Aunt(s)				
Uncle(s)				
Other				

What **exercise activities** do you do in a typical week?

Activity Type	Times per week	Minutes per activity time

SLEEP/REST

How many hours do you sleep at night? _____
Do you have trouble falling asleep? ❑ Yes ❑ No
Do you feel rested upon awakening? ❑ Yes ❑ No
Do you awaken in the middle of the night? ❑ Yes ❑ No If yes, how many times? _____
Do you urinate during regular sleep hours? ❑ Yes ❑ No If yes, how many times? _____
Do you snore? ❑ Yes ❑ No

HABITS	Yes	No	If yes, how much per day?	If quit, when?
Beer				
Wine				
Liquor				
Tobacco Products				
Marijuana				
Cocaine or other drugs				
Coffee				
Tea (with caffeine)				
Soda Regular				
Soda Diet				

SMOKING

Attempts to quit: _____
If you quit, previous smoking history: How many years? _____ Packs per day? _____
2nd Hand smoke exposure? ❑ Yes ❑ No If yes, for how long? _____

ALCOHOL

Have you ever been told you should cut down your alcohol intake? ❑ Yes ❑ No
Do you get annoyed when people ask you about your drinking? ❑ Yes ❑ No
Do you ever feel guilty about your alcohol consumption? ❑ Yes ❑ No
Do you ever take an eye-opener (alcoholic drink first thing in the morning)? ❑ Yes ❑ No
Do you notice a tolerance to alcohol (can you "hold" more than others)? ❑ Yes ❑ No
Have you ever been unable to remember what you did during a drinking episode? ❑ Yes ❑ No
Do you get into arguments or physical fights when you have been drinking? ❑ Yes ❑ No
Have you ever been arrested or hospitalized because of drinking? ❑ Yes ❑ No
Have you ever thought about getting help to control or stop your drinking? ❑ Yes ❑ No

NUTRITION

Have you ever had a nutrition consultation? ❑ Yes ❑ No
Do you currently follow a special diet or nutritional program? ❑ Yes ❑ No
Please specify:_____
Do you grocery shop? ❑ Yes ❑ No If no, who does the shopping? _____
Do you read food labels? ❑ Yes ❑ No _____
Do you cook? ❑ Yes ❑ No If no, who does the cooking? _____
How many meals do you eat out per week? ❑ 0-1 ❑ 1-3 ❑ 3-5 ❑ >5 meals per week

3 Day Food Diary Instructions

It is important to keep an accurate record of your usual food and beverage intake as a part of your treatment plan. Please complete this Diet Diary for 3 typical days including one weekend day.

- Do not change your eating behavior at this time, as the purpose of this food record is to analyze your present eating habits.
- Record information as soon as possible after the food has been consumed
- Describe the food or beverage as accurately as possible e.g., milk - what kind? (whole, 2%, nonfat); toast - (whole wheat, white, buttered); chicken - (fried, baked, breaded), coffee – (decaffeinated with sugar and 1/2 & 1/2).
- Record the amount of each food or beverage consumed using standard measurements such as 8 ounces, 1/2 cup, 1 teaspoon, etc.
- Include any added items. For example: tea with 1 teaspoon honey, potato with 2 teaspoons butter, etc.
- Record all beverages, including water, coffee, tea, sports drinks, sodas/diet sodas, etc.
- Include any additional comments about your eating habits on this form (ex. craving sweet, skipped meal and why, when the meal was at a restaurant, etc).
- Please note all bowel movements and their consistency (regular, loose, firm, etc.)

3 DAY FOOD DIARY **Name** _____

	Day 1 (Date:_____)	Day 2 (Date:_____)	Day 3 (Date:_____)
Breakfast			
Snack			
Lunch			
Snack			
Dinner			
Snack			
Water			
Bowels			
Other Comments			

Review of Symptoms

Please check all current symptoms or those present in the past 6 months

SKIN PROBLEMS

- ❑ Acne on back
- ❑ Acne on chest
- ❑ Acne on face
- ❑ Acne on shoulders
- ❑ Athlete's Foot
- ❑ Bumps on back of upper arms
- ❑ Cellulite
- ❑ Dark circles under eyes
- ❑ Ears get red
- ❑ Easy bruising
- ❑ Lack of sweating
- ❑ Eczema
- ❑ Hives
- ❑ Jock itch
- ❑ Lackluster skin colour
- ❑ Moles w/color/size change
- ❑ Oily skin
- ❑ Pale skin
- ❑ Patchy dullness
- ❑ Rash
- ❑ Red face
- ❑ Sensitive to bites
- ❑ Sensitive to poison ivy/oak
- ❑ Shingles
- ❑ Skin darkening
- ❑ Strong body odour
- ❑ Hair loss
- ❑ Vitiligo

RESPIRATORY

- ❑ Bad breath
- ❑ Bad odour in nose
- ❑ Dry cough
- ❑ Productive cough
- ❑ Hoarseness
- ❑ Sore throat
- ❑ Hay Fever
  - ❑ Spring
  - ❑ Summer
  - ❑ Fall
  - ❑ Change of season
- ❑ Nasal stuffiness
- ❑ Nose bleeds
- ❑ Post nasal drip
- ❑ Sinus infection
- ❑ Snoring
- ❑ Wheezing

CARDIOVASCULAR

- ❑ Angina/chest pain
- ❑ Breathlessness
- ❑ Heart Murmur
- ❑ Irregular Pulse
- ❑ Palpitations
- ❑ Phlebitis
- ❑ Swollen Ankles/Feet
- ❑ Varicose Veins

ITCHING SKIN

- ❑ Skin in General
- ❑ Anus
- ❑ Arms
- ❑ Ear Canals
- ❑ Eyes
- ❑ Feet
- ❑ Hands
- ❑ Legs
- ❑ Nipples
- ❑ Nose
- ❑ Penis
- ❑ Roof of Mouth
- ❑ Scalp
- ❑ Throat

SKIN, DRYNESS OF

- ❑ Eyes
- ❑ Feet
  - ❑ Any cracking?
  - ❑ Any peeling?
- ❑ Hands
  - ❑ Any cracking?
  - ❑ Any peeling?
- ❑ Hair
- ❑ Mouth/Throat
- ❑ Scalp
- ❑ Any dandruff?
- ❑ Skin In General

LYMPH NODES

- ❑ Enlarged - neck
- ❑ Tender - neck
- ❑ Other enlarged/tender

NAILS

- ❑ Bitten
- ❑ Brittle
- ❑ Curve Up
- ❑ Frayed
- ❑ Fungus-Fingers
- ❑ Fungus-Toes
- ❑ Pitting
- ❑ Ragged cuticles
- ❑ Ridges

Soft Thickening of:

- ❑ Finger Nails
- ❑ Toenails

- ❑ White spots/lines

URINARY

- ❑ Bed wetting
- ❑ Hesitancy (trouble getting started)
- ❑ Infection
- ❑ Kidney Disease
- ❑ Leaking/incontinence
- ❑ Pain/Burning
- ❑ Prostate Infection
- ❑ Urgency

MALE REPRODUCTIVE

- ❑ Discharge From Penis
- ❑ Ejaculation Problem
- ❑ Genital Pain
- ❑ Impotence
- ❑ Prostate or Urinary Infection
- ❑ Lumps In Testicles
- ❑ Poor Libido (Sex Drive)

FEMALE REPRODUCTIVE

- ❑ Breast cysts
- ❑ Breast lumps
- ❑ Breast tenderness
- ❑ Ovarian Cyst
- ❑ Poor libido (Sex Drive)
- ❑ Vaginal discharge
- ❑ Vaginal odor
- ❑ Vaginal itch
- ❑ Vaginal pain with sex

Premenstrual:

- ❑ Bloating
- ❑ Breast tenderness
- ❑ Carbohydrate cravings
- ❑ Chocolate craving
- ❑ Constipation
- ❑ Decreased sleep
- ❑ Diarrhea
- ❑ Fatigue
- ❑ Increased sleep
- ❑ Irritability

Menstrual:

- ❑ Cramps
- ❑ Heavy periods
- ❑ Irregular periods
- ❑ No periods
- ❑ Scanty periods
- ❑ Spotting between periods

Menopausal:

- ❑ Hot Flashes
- ❑ Mood Swings
- ❑ Concentration/Memory issues
- ❑ Vaginal dryness
- ❑ Decreased libido
- ❑ Heavy bleeding
- ❑ Joint pains
- ❑ Headaches
- ❑ Weight gain
- ❑ Loss of control of urine
- ❑ Palpitations

GENERAL

- ❑ Cold hands and feet
- ❑ Low body temperature
- ❑ Cold intolerance
- ❑ Daytime sleepiness
- ❑ Low blood pressure
- ❑ Difficulty falling asleep
- ❑ Early waking
- ❑ Fatigue
- ❑ Fever
- ❑ Flushing
- ❑ Heat intolerance
- ❑ Night waking
- ❑ Nightmares
- ❑ No dream recall

HEAD, EYES & EARS

- ❑ Conjunctivitis
- ❑ Distorted sense of smell
- ❑ Distorted taste
- ❑ Ear fullness
- ❑ Ear pain
- ❑ Ear ringing/buzzing
- ❑ Lid margin redness
- ❑ Eye crusting
- ❑ Eye pain
- ❑ Hearing loss
- ❑ Hearing problems
- ❑ Headache
- ❑ Migraine
- ❑ Sensitivity to loud noises
- ❑ Visual problems (not glasses)
- ❑ Macular degeneration
- ❑ Vitreous detachment
- ❑ Retinal detachment

MUSCULOSKELETAL

- ❑ Back muscle spasm
- ❑ Calf cramps
- ❑ Chest tightness
- ❑ Foot cramps
- ❑ Joint deformity
- ❑ Joint pain
- ❑ Joint redness
- ❑ Joint stiffness
- ❑ Muscle pain
- ❑ Muscle spasms
- ❑ Muscle stiffness
- Muscle twitches
  - ❑ Around eyes
  - ❑ Arms or legs
- ❑ Muscle weakness
- ❑ Neck muscle spasm
- ❑ Tendonitis
- ❑ TMJ problems

MOOD/NERVES

- ❑ Agoraphobia
- ❑ Anxiety
- ❑ Auditory Hallucinations
- ❑ Blackout
- ❑ Depression

Difficulty:

- ❑ concentrating
- ❑ with judgment
- ❑ with balance
- ❑ with thinking
- ❑ with memory
- ❑ with speech

- ❑ Dizziness
- ❑ Fainting
- ❑ Fearfulness
- ❑ Irritability
- ❑ Light-headedness
- ❑ Numbness
- ❑ Other phobias
- ❑ Panic attacks
- ❑ Paranoia
- ❑ Pins and needles sensation
- ❑ Seizures
- ❑ Suicidal thoughts
- ❑ Tremor/trembling
- ❑ Visual hallucinations

EATING

- ❑ Binge eating
- ❑ Bulimia
- ❑ Can't gain weight
- ❑ Can't lose weight
- ❑ Can't maintain weight
- ❑ Frequent dieting
- ❑ Poor appetite
- ❑ Salt cravings
- ❑ Sweet cravings
- ❑ Carb cravings (bread,pasta)
- ❑ Chocolate cravings
- ❑ Caffeine dependent

DIGESTION

- ❑ Anal spasms
- ❑ Bad teeth
- ❑ Bleeding gums
- Bloating of:
  - ❑ lower abdomen
  - ❑ whole abdomen
  - ❑ after meals
- ❑ Blood in stools
- ❑ Burping
- ❑ Canker sores
- ❑ Cold sores
- ❑ Constipation
- ❑ Cramps
- ❑ Cracks at corners of lips
- ❑ Diarrhea
- ❑ Alternating diarrhea/constipation
- ❑ Difficulty swallowing
- ❑ Dry mouth
- ❑ Excessive flatulence/gas
- ❑ Fissures
- ❑ Foods "repeat" (reflux)
- ❑ Gas
- ❑ Heartburn
- ❑ Hemorrhoids
- ❑ Indigestion
- ❑ Nausea
- ❑ Upper abdominal pain
- ❑ Vomiting
- ❑ Abnormal liver tests
- ❑ Liver disease/jaundice (yellow eyes or skin)
- ❑ Lower abdominal pain

Intolerance to:

- ❑ Lactose
- ❑ All dairy products
- ❑ Wheat
- ❑ Gluten
- ❑ Corn
- ❑ Eggs
- ❑ Fatty foods
- ❑ Yeast

- ❑ Mucus in stools
- ❑ Periodontal disease
- ❑ Sore tongue
- ❑ Strong stool odour
- ❑ Undigested food in stool

WOMEN'S HEALTH (if applicable)

Age of first menstrual period_____ Age at Menopause (if applicable) _____
Date of last PAP_____
Have you ever had an abnormal PAP? (circle one) ❑ YES ❑ NO If yes, when_____
Last Mammogram_____
Most recent Breast exam_____
Last Bone Density_____
Most recent pelvic exam_____
Length of menstrual cycle_____
Number of pregnancies_____ Live births_____ Miscarriages/Abortions_____

Use of hormonal contraception such as: ❑ Birth Control Pills ❑ Patch ❑Nuva Ring How long?_____
Do you use other contraception? ❑ Yes ❑ No ❑ Condom ❑ Diaphragm ❑ IUD ❑ Partner vasectomy
Use of hormone replacement therapy? ❑ Yes ❑ No If yes, how long?_____

RELATIONSHIPS/PSYCHOSOCIAL

Marital status: ❑ Single ❑ Married ❑ Divorced ❑ Gay/Lesbian ❑ Long Term Partnership ❑ Widow

With whom do you live? (include roommates, friends, partner, spouse, children, parents, relatives, pets)

Name	Age	Relationship	Name	Age	Relationship

RESOURCES FOR EMOTIONAL SUPPORT?

Check all that apply: ❑ Spouse ❑ Family ❑ Friends ❑ Religious/Spiritual ❑ Pets ❑ Other: _____
Are you satisfied with your **sex life**? ❑ Yes ❑ No
What is your **occupation**? _____
Highest **education** level ☐ High School ☐ University ☐ Masters ☐ Post Graduate
Religious or Spiritual affiliation (past present or none)?_____

STRESS

Do you feel you have an excessive amount of stress in your life? ❑ Yes ❑ No
Do you feel you can easily handle the stress in your life? ❑ Yes ❑ No
Daily Stressors: *Rate on scale of 1-10*
Work _____ Family _____ Social _____ Finances_____ Health_____ Other_____
Do you practice meditation or relaxation technique? ❑ Yes ❑ No If yes, how often? _____
Check all that apply: ❑ Yoga ❑ Meditation ❑ Imagery ❑ Breathing ❑ Tai Chi ❑ Prayer ❑ Other: _____
Have you ever been abused, a victim of a crime, or experienced a significant trauma? ❑ Yes ❑ No

MOTIVATION ASSESSMENT

Rate on a scale of: 5 (very willing) to 1 (not willing).

In order to improve your health, how willing are you to:
Significantly modify your diet: ❑ 5 ❑ 4 ❑ 3 ❑ 2 ❑ 1
Take several nutritional supplements each day: ❑ 5 ❑ 4 ❑ 3 ❑ 2 ❑ 1
Keep a record of everything you eat each day: ❑ 5 ❑ 4 ❑ 3 ❑ 2 ❑ 1
Modify your lifestyle (e.g: work demands, sleep habits): ❑ 5 ❑ 4 ❑ 3 ❑ 2 ❑ 1
Practice a relaxation technique: ❑ 5 ❑ 4 ❑ 3 ❑ 2 ❑ 1
Engage in regular exercise: ❑ 5 ❑ 4 ❑ 3 ❑ 2 ❑ 1
Have periodic lab tests to assess your progress: ❑ 5 ❑ 4 ❑ 3 ❑ 2 ❑ 1

Is there any **other information** about you that you would like us to know?

_____

_____

_____

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_____

Multiple Symptoms Questionnaire (MSQ)

The Toxicity and Symptom Screening Questionnaire identifies symptoms that help to identify the underlying causes of illness, and helps you track your progress over time. Rate each of the following symptoms based upon your health profile for the past 30 days. If you are taking after the first time, record your symptoms for the last 48 hours ONLY.

POINT SCALE

0 = Never or almost never have the symptom
1 = Occasionally have it, effect is not severe
2 = Occasionally have, effect is severe
3 = Frequently have it, effect is not severe
4 = Frequently have it, effect is severe

MOUTH/THROAT
___ Chronic coughing
___ Gagging, frequent need to clear throat
___ Sore throat, hoarseness, loss of voice
___ Swollen/discolored tongue, gum, lips
___ Canker sores
Total _____

NOSE
___ Stuffy nose
___ Sinus problems
___ Hay fever
___ Sneezing attacks
___ Excessive mucus formation
Total _____

SKIN
___ Acne
___ Hives, rashes, or dry skin
___ Hair loss
___ Flushing or hot flushes
___ Excessive sweating
Total _____

WEIGHT
___ Binge eating/drinking
___ Craving certain foods
___ Excessive weight
___ Compulsive eating
___ Water retention
___ Underweight
Total _____

OTHER
___ Frequent illness
___ Frequent or urgent urination
___ Genital itch or discharge
Total _____

DIGESTIVE TRACT
___ Nausea or vomiting
___ Diarrhea
___ Constipation
___ Bloated feeling
___ Belching, or passing gas
___ Heartburn
___ Intestinal/Stomach pain
Total _____

EARS
___ Itchy ears
___ Earaches, ear infections
___ Drainage from ear
___ Ringing in ears, hearing loss
Total _____

EMOTIONS
___ Mood swings
___ Anxiety, fear or nervousness
___ Anger, irritability, or aggressiveness
___ Depression
Total _____

ENERGY/ACTIVITY
___ Fatigue, sluggishness
___ Apathy, lethargy
___ Hyperactivity
___ Restlessness
Total _____

EYES
___ Watery or itchy eyes
___ Swollen, reddened or sticky eyelids
___ Bags or dark circles under eyes
___ Blurred or tunnel vision (does not include near-or far-sightedness)
Total _____

HEAD
___ Headaches
___ Faintness
___ Dizziness
___ Insomnia
Total _____

HEART
___ Irregular or skipped heartbeat
___ Rapid or pounding heartbeat
___ Chest pain
Total _____

JOINTS/MUSCLES
___ Pain or aches in joints
___ Arthritis
___ Stiffness or limitation of movement
___ Pain or aches in muscles
___ Feeling of weakness or tiredness
Total _____

LUNGS
___ Chest congestion
___ Asthma, bronchitis
___ Shortness of breath
___ Difficult breathing
Total _____

MIND
___ Poor memory
___ Confusion, poor comprehension
___ Poor concentration
___ Poor physical coordination
___ Difficulty in making decisions
___ Stuttering or stammering
___ Slurred speech
___ Learning disabilities
Total _____

GRAND TOTAL_____

KEY TO QUESTIONNAIRE

Add individual scores and total each group. Add each group scores and give a grand total.

• **Optimal** is less than 10 • **Mild** Toxicity: 10-50 • **Moderate** Toxicity: 50-100 • **Severe** Toxicity: over 100